**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**MAINECARE HOME HEALTH ADMIT/DISCHARGE FORM (AGE 21 AND OLDER)**

**Member:** _____ **Provider Name:** _____

**MaineCare Number:** ☐☐☐☐☐☐☐☐☐ **Provider Telephone:** _____

**Provider Contact Person:** _____ **Provider Fax:** _____

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☐ **NEW ADMIT TO YOUR AGENCY (send only to BEAS Fax # 287-9231)** **Original Start of Care Date:** ___/___/___

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☐ **Psychiatric Medication Services ONLY:** Member has a severe and disabling mental illness that meets the eligibility requirement set forth in Section 17. The only service covered is medication administration or monitoring.

**RN Start of Care:** ___/___/___

**(ANY ADDITIONAL HOME HEALTH SERVICES REQUIRE PRIOR AUTHORIZATION UNDER THIS EXEMPTION)**

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**Current Plan of Care Services** **Check appropriate Box:** **1st Certification Period** ☐ **2nd Certification Period** ☐

| | Start of Care |
|---|---|
| ☐ * RN - Teach and Train | ____/____/____ |
| ☐ * RN Assessment Management♦ | ____/____/____ |
| ☐ RN - Skilled Nursing | ____/____/____ |
| ☐ Psychiatric Medication Services (when receiving additional services) | ____/____/____ |
| ☐ Home Health Aide | ____/____/____ |
| ☐ MSW (not allowed as stand alone – must also have RN, PT, OT or ST) | ____/____/____ |

**PA REQUIRED AFTER THE FIRST 120 DAYS FOR ALL CATEGORIES OF SERVICE IN THIS SECTION, EXCLUDING PSYCHIATRIC MEDICATION SERVICES – SEE ABOVE**

♦For new/recent medical condition w/in past 30 days

*** Limited to 120 days per admission**

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| | | |
|---|---|---|
| ☐ Physical Therapy | ____/____/____ | **PA IS REQUIRED IF PT EXCEEDS 20 VISITS/ FISCAL YEAR** |
| ☐ Occupational Therapy | ____/____/____ | **PA IS REQUIRED IF OT EXCEEDS 20 VISITS/ FISCAL YEAR** |
| ☐ Speech Therapy | ____/____/____ | **PA IS REQUIRED IF ST EXCEEDS 35 VISITS/FISCAL YEAR** |

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| **DISCHARGED TO (SEND ONLY TO BEAS FAX # 287-9231)** | **HOME HEALTH END DATE** |
|---|---|
| Long-term Care Program (name) _____ | Date _____ |
| Home, Medicare/3rd party payer service | Date _____ |
| Home, no service | Date _____ |
| Hospital | Date _____ |
| Residential Care (name) _____ | Date _____ |
| Nursing Facility (name) _____ | Date _____ |
| Death | Date _____ |

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Person completing this form: _____ Date _____